1.HealthNet Policy Number	I038-000-120415701-01	2. Authorization Code:
2.Patient Name	CHADIA LARDI	
3.Patient Date of Birth & Sex	19-11-02(dd/mm/yy)	☐ Male ☑ Female
	Mobile No.0544683610	
5.Nature of illness or Injury	☐ Acute ☐ Chronic ☐ Emergency	
6.Are You the patient's primary physician	☐ Yes ☐ No	

7.Presenting Complaints:

co pain in lower abdominal severe lmp 26may 2024

oe

pain in lower abdominal region she was not doing any sexsual activity in the last month

chest is clear no addded sounds

restless

8.Duration of Symptoms:

9.Onset of Condition:

10.Relevent Past Medical/Surfgical History

Diagonosisi Lower abdominal pain, unspecified, Irregular menstruation, unspecified — ICD Code R10.30, N92.6

12.Etiology:

13.In case of Injury:mode of Injury/place of Injury

14.Plan / Details of Management

a.Procedure Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with — CPT code 9,84703,81001

other providers or agencies are provided consistent with the nature of the problem(s) and the patients and/or familys needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.,Gonadotropin Chorionic Qualitative,Urnls Dip Stick/Tablet Reagent Auto Microscopy

b.Laboratiry Test:

c.Radiology / Investigations:

15.In Case of Hospitalization: Date of Addmission: Date of Discharge:

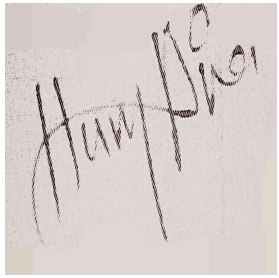
16.

PRESCRIPTION WITH DOSAGE & DURATION

Code	Generic	Dosage	Duration	Instructions
0067-181302-0392	(MEFENAMIC ACID : 500 MG) FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK)	5	Take 1Tablets 2 Time(s) per Day For 5 Day(s) others

Date: 01-07-24(dd/mm/yy)

Signature and Stamp



Dr. Humaira Mumtaz
General Practitioner
DHA No: 54155530-002
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Doctor's Name Humaira

Physician Code DHA-P-54155530 HNM Code

Authorization

I hereby authorize the Physician, Hospital or Pharmacy to file a claim for medical services on my behalf and I confirm that the above mentioned examination / investigation / therapy is given to me by the doctor. I hereby authorize any Hospital, Physician, Pharmacy or any other person who has provided medical services to me or my dependents to furnish NGI with any and all information with regard to any medical history, medical condition or medical services and copies of all medical and hospital records.

A Photocopy or teletax copy of this authorization shall be considered effective any valid as the original

Date: 01-07-24(dd/mm/yy) Signature of Insued / Claimint

Copy of NGI - Pharmacy

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